

Privileges in Physical Medicine & Rehabilitation Service

Name: _____
Please Print

MEDICAL STAFF CATEGORY REQUESTED:

- Active** – Uses Stanford Hospital & Clinics (SHC) as a primary hospital and regularly admits/treats, consults, patients at this facility, or is regularly involved in medical staff functions.
Minimum 11 pt contacts per year
- Courtesy-Admitting** – Member in good standing in another TJC, AAAHC or AAAASF accredited hospital.
Admits/treats 3 – 10 patients per year at SHC
- Courtesy-Teaching** – Treats SHC patients only when incident to performing clinical teaching responsibilities.
Must have teaching appointment with the Stanford School of Medicine
- ONLY** provide care of patients in the SHC Emergency Department, ASC, Cath Lab, Cancer Center or Endo Unit – *requires Active or Courtesy Status at LPCH*

Please indicate any teaching title you may hold with the Stanford School of Medicine:

- Faculty (MCL, CE or UTL)
- Adjunct Clinical Faculty

Teaching Title: _____

REQUESTED	PROCEDURE	INITIAL CRITERIA	RENEWAL CRITERIA	PROCTORING REQUIREMENTS
PHYSICAL MEDICINE & REHABILITATION CORE PRIVILEGES				
<input type="checkbox"/>	<p><u>Privileges included in the Core: **</u> Privileges to admit, evaluate, diagnose, consult, perform history and physical exam, and treat patients with diminished physical, social, psychological, or cognitive capabilities.</p> <p><u>Cross out & INITIAL any privilege/s you are not applying for in this set of Basic Privileges</u></p> <p>Core privileges include:</p> <ul style="list-style-type: none"> • Inpatient and outpatient musculoskeletal and neuromuscular diagnosis and rehabilitation • Musculoskeletal injection (fluoroscopy) • Nerve injection • Medical and rehabilitative pain management • Injury prevention and wellness • Nonsurgical spine medicine • Sports medicine including athletes with disabilities • Prescribing orthotic and prosthetic devices 	<p>Successful completion of an ACGME or AOA-accredited residency/fellowship in physical medicine and rehabilitation or foreign equivalent training.</p> <p align="center"><u>AND Either</u></p> <p>Current certification or active participation in the examination process leading to certification in physical medicine and rehabilitation by the American Board of Physical Medicine & Rehabilitation or foreign equivalent training/board.</p> <p align="center"><u>OR</u></p> <p>Documentation or attestation of the provision of inpatient care or consultative services for at least 100 physical medicine and rehabilitation patients as the attending physician (or senior resident), at an accredited facility, during the past two years.</p>	<p><i>Reappointments: please be prepared to provide a list of cases performed at facilities other than SHC if requested.</i></p> <p>Appropriate number of cases performed per year as based on Category</p> <p>_____ # of cases in past 2 years</p> <p>Minimum 50 cases required</p>	5 Chart Reviews

SPECIAL PRIVILEGES				
(MUST ALSO MEET THE CRITERIA ABOVE FOR EITHER PHYSICAL MEDICINE AND REHAB OR SPORTS MEDICINE)				
REQUESTED	PROCEDURE	ADDITIONAL CREDENTIALING CRITERIA	Renewal Criteria # of Cases performed in past 2 yrs **	Proctoring Requirements
<input type="checkbox"/>	Administration of Moderate Sedation	In accordance with Hospital Sedation Policy and completion of the SHC sedation exam	Sedation exam every 4 years _____ # of cases in past 2 years (minimum 5 cases required)	1 Chart Review
<input type="checkbox"/>	Use of fluoroscopy equipment (or supervision of other staff using the equipment)	'Radiology Supervisor and Operator Certificate' or 'Fluoroscopy Supervisor and Operator Permit' required	Maintenance of valid Fluoroscopy or Radiology Certificate _____ # of cases in past 2 years (minimum 20 cases required)	
<input type="checkbox"/>	Treatment of patients in outpatient clinics at Stanford Hospital & Clinics	Must have teaching appointment through the Stanford School of Medicine.		
<input type="checkbox"/>	Admit, treat, or provide follow-up care for inpatients ages 14 years or younger	Must have membership and privileges at Lucile Packard Children's Hospital	_____ # of cases in past 2 years (minimum 20 cases required)	
<input type="checkbox"/>	Spinal cord injury medicine	Current certification or active participation in the examination process leading to certification in physical medicine and rehabilitation by the American Board of Physical Medicine & Rehabilitation or the American Osteopathic Board of Rehabilitation Medicine	_____ # of cases in past 2 years (minimum 20 cases required)	3 Chart Reviews
<input type="checkbox"/>	Pain management	Current certification or active participation in the examination process leading to certification in physical medicine and rehabilitation by the American Board of Physical Medicine & Rehabilitation or the American Osteopathic Board of Rehabilitation Medicine	_____ # of cases in past 2 years (minimum 20 cases required)	5 Chart Reviews
<input type="checkbox"/>	Nerve blocks	Current certification or active participation in the examination process leading to certification in physical medicine and rehabilitation by the American Board of Physical Medicine & Rehabilitation or the American Osteopathic Board of Rehabilitation Medicine	_____ # of cases in past 2 years (minimum 5 cases required)	1 Chart Reviews
<input type="checkbox"/>	Motor point blocks	Current certification or active participation in the examination process leading to certification in physical medicine and rehabilitation by the American Board of Physical Medicine & Rehabilitation or the American Osteopathic Board of Rehabilitation Medicine	_____ # of cases in past 2 years (minimum 5 cases required)	1 Chart Reviews
<input type="checkbox"/>	Interventional spine and intradiscal therapies	ACGME accredited Pain Management Fellowship or Spine Fellowship with documentation of a minimum 50 cases within the past year (need to submit documentation log)	_____ # of cases in past 2 years (minimum 20 cases required)	5 Chart Reviews
<input type="checkbox"/>	Electrodiagnostic procedures	Current certification or active participation in the examination process leading to certification in physical medicine and rehabilitation by the American Board of Physical Medicine & Rehabilitation or the American Osteopathic Board of Rehabilitation Medicine	_____ # of cases in past 2 years (minimum 5 cases required)	5 Chart Reviews

<input type="checkbox"/>	Radiofrequency Lesioning of Medial Branch Nerves (lumbar, thoracic)	ACGME accredited Pain Management Fellowship or Spine Fellowship with documentation of a minimum 50 cases within the past year (need to submit documentation log)	_____ # of cases in past 2 years (minimum 10 cases required)	1 observation 2 Chart Reviews
<input type="checkbox"/>	Radiofrequency Lesioning of Medial Branch Nerves (cervical)	ACGME accredited Pain Management Fellowship or Spine Fellowship with documentation of a minimum 50 cases within the past year (need to submit documentation log)	_____ # of cases in past 2 years (minimum 10 cases required)	1 observation 2 Chart Reviews
<input type="checkbox"/>	Cervical Epidural Steroid Injection w/MAC	ACGME accredited Pain Management Fellowship or Spine Fellowship with documentation of a minimum 50 cases within the past year (need to submit documentation log)	_____ # of cases in past 2 years (minimum 20 cases required)	1 observation 2 Chart Reviews
<input type="checkbox"/>	Acupuncture	Must complete Acupuncture Privilege Form		

**** On a separate sheet of paper, please describe any major, unexpected complications you have encountered for any of the Core Privileges or Additional Privileges you are requesting**

NOTE: PROCTORING IS REQUIRED FOR ALL INITIAL PRIVILEGES REQUESTED and MUST BE COMPLETED WITHIN 12 MONTHS

ACKNOWLEDGMENT OF PRACTITIONER:

I have requested only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform, and that I wish to exercise at Stanford Hospital & Clinics. I also acknowledge that my professional malpractice insurance extends to all privilege I have requested.

I understand that in exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

Applicant Signature: _____ Date _____

If sending by email, type your name in the box above.

If sending by mail, please print first and then sign.